Pharmacy
Pharmacist, Ms B

A Report by the
Deputy Health and Disability Commissioner

(Case 20HDC00383)

Health and Disability Commissioner
Te Toihau Hauora, Hauātanga

Contents

Executive summary

1. This report concerns a pharmacist's failure to check a medication adequately before it was handed over to the consumer. The report highlights the importance of pharmacists undertaking adequate checks, and of pharmacies responding appropriately when errors occur.

Findings

2. The Deputy Commissioner considered that by not checking the dispensed medication adequately, and thus allowing an incorrect medicine to be dispensed, the pharmacist failed to adhere to the professional standards set by the Pharmacy Council of New Zealand, in breach of Right 4(2) of the Code.

3. The Deputy Commissioner also found that by failing to undertake an adequate review, in accordance with its SOPs, the pharmacy missed an opportunity to identify how the error occurred, and to identify actions to minimise such errors in the future. Accordingly, the pharmacy was found to have breached Right 4(1) of the Code.

Recommendations

4. The Deputy Commissioner noted that the pharmacist has provided HDC with a written apology and made a number of changes to her practice in response to the complaint. He recommended the pharmacist provide evidence of her completion of the Improving Accuracy and Self-Checking Workbook to HDC within three weeks of the date of this report.

5. The Deputy Commissioner recommended that the pharmacy provide a written formal apology for the breach of the Code identified in this report, and outline the actions taken by the pharmacy to prevent such an error happening again; arrange refresher training for its staff in relation to dispensing and checking medications and dispensing error; consider the recommendations made by the expert advisor, and outline any further actions the pharmacy plans to take; report back to HDC regarding the pharmacy's consideration to employ an extra pharmacist when a new pharmacist manager is starting, to improve the support and coverage; undertake a random audit of the dispensing and checking of medication of 20 prescriptions over a one-month period to assess compliance with the dispensing and checking SOPs; and undertake a review of any dispensing errors in the last six months, including whether management of the error complied with the Dispensing Error SOP.

Complaint and investigation

6. The Health and Disability Commissioner (HDC) received a complaint from Mrs A about the services provided to her daughter (Miss A) by a pharmacy. The following issues were identified for investigation:

- *Whether the pharmacy provided Miss A with an appropriate standard of care between August 2019 and February 2020 (inclusive).*
- *Whether Ms B provided Miss A with an appropriate standard of care between August 2019 and February 2020 (inclusive).*

7. This report is the opinion of Deputy Health and Disability Commissioner Kevin Allan, and is made in accordance with the power delegated to him by the Commissioner.

8. The parties directly involved in the investigation were:

Mrs A	Complainant
Pharmacy	Provider
Ms B	Provider/pharmacist

9. Further information was received from Ms C, a dispensary technician.

10. Independent expert advice was obtained from a pharmacist, Ms Sharynne Fordyce (Appendix A).

Information gathered during investigation

Introduction

11. Miss A (in her teens at the time of events) was prescribed medication for migraines (sumatriptan 50mg tablets). On 8 August 2019, a medication used to treat depression, obsessive-compulsive disorder, panic attacks, anxiety, or post-traumatic stress disorder (sertraline 50mg tablets[1]) was mistakenly dispensed instead of sumatriptan. The error was discovered over six months later by Miss A's school nurse.

12. This report concerns the error in dispensing the medication to Miss A, and the pharmacy's response to the error.

[1] Ten tablets prescribed with direction to take one tablet as a single does when required for a migraine and to repeat the dose once after at least two hours if migraine recurs. Maximum of two tablets in 24 hours. A total of 10 tablets were supplied.

Dispensing error

13. At 2.41pm on 8 August 2019, Miss A's mother, Mrs A, went to the pharmacy to fill a script for sumatriptan.

14. Mrs A presented with the script at the busiest time of the day at the pharmacy (20 scripts were dispensed between 2.00pm and 3.00pm). The pharmacy said that it was not an unusually busy day.

15. There is no documentation regarding who dispensed sertraline instead of sumatriptan, as the prescription form was not initialled. The pharmacy told HDC that it believed that Ms C, a dispensary technician,[2] may have been on a break at the time of dispensing, and that Ms B, the Manager/Sole-Charge Pharmacist,[3] dispensed and checked the medication. It was Ms B's first day working at the pharmacy.

16. Subsequently, however, Ms B told HDC that Ms C was not on break, and was dispensing prescriptions. Ms B said that Ms C processed Miss A's prescription and dispensed the medication, as the ticks on the prescription are Ms C's, and this is her usual dispensing process. Ms C told HDC that she was present in the pharmacy and dispensing the regular medications on the day, so it is likely that she dispensed the medication. The two medications, sertraline and sumatriptan, were next to each other on the shelf.

17. Ms B undertook the final check of the prescription and medication. She said that unfortunately she did not notice that sertraline had been dispensed instead of sumatriptan. Sertraline was then given to Mrs A.

18. According to the pharmacy's SOPs, the final check involves checking the dispensed medicine against the prescription for accuracy, including ensuring that it is the correct medicine, dose, form, strength, and quantity, and checking for any interactions. After completing the final check, the pharmacist is to sign the prescription.

Discovery of dispensing error

19. Ms B told HDC that on 25 February 2020, around six months after sertraline was dispensed incorrectly, a nurse at Miss A's school telephoned the pharmacy. Ms B said that the nurse advised that she had noticed that the medication inside Miss A's medication pack did not match its label, and she was not sure whether it was a dispensing error or someone else's medication in the box. Ms B told HDC that she asked the nurse to tell Mrs A to come to the pharmacy with the incorrect medication.

[2] The Dispensary Technician job description outlines that they are responsible for "accurate and efficient dispensing of pharmaceuticals" and "compounding, labelling, dispensing and checking prescriptions to customers safely, efficiently, accurately, systematically in accordance with company procedures".

[3] The Business Manager job description outlines that they are responsible for "ensur[ing] compliance with ethical, professional and legal pharmacy standards to ensure that every customer receives a safe, accurate and efficient dispensing service".

Management of dispensing error

20. Ms B told HDC that as soon as she was made aware of the incident, she telephoned Miss A's GP and reported the error to the Pharmacy Defence Association. She completed a Pharmacy Defence Association Incident Notification Form (the Incident Form) on 25 February 2020. She outlined that Mrs A wanted to make a complaint (and that she had provided Mrs A with a Health and Safety pamphlet[4]), and that she immediately separated the two medications (sertraline and sumatriptan) on the shelf far from each other with a red sticker underneath saying to be aware of name similarity.

21. On 26 February 2020, Mrs A went to the pharmacy but did not take the incorrectly dispensed medication back to the pharmacy. Ms B said: "I took [Mrs A's] word that we had made an error." Ms B told HDC that she apologised to Mrs A verbally for the error. Ms B said that Mrs A told the pharmacy that she did not want her daughter to know about the mistake, and said that she would take her daughter to the GP.

22. Ms B told HDC that she had needed a couple of days to investigate the matter and get back to Mrs A with some explanations, as the error had happened the previous year. However, Ms B was on leave from 28 February 2020 and then sustained an injury on 29 February 2020 causing her to be off work for four months. The pharmacy did not contact Mrs A further about the error or conduct any further investigation at this time. Neither Ms B nor the pharmacy provided a written apology to Mrs A at this time, and the incorrectly dispensed sertraline was not retrieved by the pharmacy.

23. In August 2020, after Mrs A made a complaint to HDC,[5] the pharmacy told Ms B that HDC required a statement from her. Ms B said that it crossed her mind to ring Mrs A at that time, but she felt that it was too late.

24. The pharmacy told HDC that the delay in investigation was caused by Ms B's accident, and the time it took to respond was affected by increased workload over the COVID-19 period,[6] in conjunction with Ms B requiring a long period off as a result of her injury.

Further information

Ms B

25. Prior to starting her job at the pharmacy, Ms B had worked in hospital pharmacies as a clinical pharmacist, and in other pharmacies as a pharmacist manager.

26. Ms B told HDC that unfortunately her checking process failed her when checking the prescription for Miss A. She explained that a possible factor that caused the error was that it was her first day at the pharmacy and it was a new environment.

[4] The pharmacy has explained that the pamphlet referred to in the Incident Form was a pamphlet for the Office of the Health and Disability Commissioner.
[5] HDC received the complaint on 26 February 2020.
[6] New Zealand went into Level 4 lockdown on 25 March 2020.

27. Ms B's job description outlined that the Manager/Sole-Charge pharmacist was responsible for ensuring compliance with ethical, professional, and legal pharmacy standards to ensure that every customer received a safe, accurate, and efficient dispensing service.

28. The pharmacy told HDC that before starting, Ms B met with staff to become familiar with the dispensary layout. The pharmacy also said that Ms B had no formal handover from the previous pharmacist manager because this person had already left the pharmacy before Ms B started. However, a dispensary manager (who was previously a dispensary technician) had communicated with Ms B to ensure that she had the information to become oriented with the pharmacy processes prior to commencing work. The pharmacy said that on Ms B's first day, the previous dispensary manager was also rostered on that morning, and the company also owns another pharmacy in the area that was available by telephone for professional support.

29. The pharmacy told HDC that it considers that this was an isolated incident, and not representative of Ms B's usual high level of professional practice. Ms B accepted that the wrong medicine was dispensed owing to human error, and that the pharmacy's Standard Operating Procedures (SOPs) were not followed.

30. The pharmacy told HDC that the care provided by Ms B was inappropriate to the extent that the wrong medicine was checked and not picked up owing to human error, and that the SOP had not been followed, as the dispenser had not initialled the prescription.

SOPs

31. A copy of the pharmacy's relevant SOPs was provided to HDC, and the relevant extracts of these SOPs are included as Appendix B. The SOPs were not the primary healthcare group's[7] standard SOPs.

32. The pharmacy told HDC that the Ministry of Health does not require the pharmacy to hold standard primary healthcare group SOPs, and its SOPs have passed the Ministry of Health audit.

Responses to provisional opinion

33. Mrs A, Ms B, and the pharmacy were given an opportunity to respond to relevant sections of the provisional opinion.

34. Ms B told HDC that retrieving the medication was definitely a priority for her, but because of her unforeseen injury and leave, she was unable to follow this up further.

35. The pharmacy did not provide further input into the provisional opinion and stated that it would focus its attention on the "corrective actions requested". The pharmacy said that it would be conducting the annotation audit within the next two weeks.

[7] A provider of primary healthcare services to communities in New Zealand. SOPs are a set of step-by-step instructions compiled by an organisation to help workers to carry out routine operations.

36. Mrs A commented on the impact that the dispensing error has had on her and her daughter. Mrs A recollected watching her daughter suffer migraines and encouraging her to take the medication, believing that it was correct and would help. Mrs A told HDC that this issue has caused her daughter to struggle to take medications. Mrs A also commented that, at the time, all she wanted was an apology and empathy and felt she received neither.

Opinion: Ms B

37. As a registered pharmacist, Ms B was responsible for ensuring that she provided services of an appropriate standard to Miss A, including complying with the professional standards set by the Pharmacy Council Code of Ethics (appended to this report).

Dispensing error — breach

38. Miss A was incorrectly given sertraline (medication for depression and anxiety) instead of sumatriptan (medication for migraines). Whilst the pharmacy advised that it is likely that Ms C, a pharmacy technician, dispensed the medication, this cannot be confirmed, as the dispensing was not initialled. In any event, it is not disputed that in line with the pharmacy's SOPs and professional standards, it was Ms B's responsibility as the pharmacist to complete the final check of the incorrectly dispensed sertraline before it was given to Mrs A.

39. Ms B said that a possible reason for the dispensing error was that it was her first day at the pharmacy, and the two medications were stored next to each other. Ms B accepts that she did not identify that the incorrect medication was being dispensed during her final check, and that she did not follow the SOPs.

40. The Pharmacy Council of New Zealand's Competence Standards for the Pharmacy Profession (2015) provides that a pharmacist "[m]aintains a logical, safe and disciplined dispensing procedure", "[a]cts to optimise health outcomes by identifying and mitigating potential sources of error in service delivery", and "[f]ollows relevant policies, procedures and documentation requirements for the administration of medicines".

41. My expert adviser, pharmacist Ms Sharynne Fordyce, advised that Ms B's failure to notice the selection and dispensing of the incorrect stock in her final check constituted a departure from accepted practice.

42. I accept this advice. While it was Ms B's first day at the pharmacy, she was a pharmacist with more than 20 years' experience, and was appointed as the manager. I acknowledge that the names of the two medications are similar, but Ms B had a professional responsibility to take appropriate steps to ensure the provision of safe and accurate services. It is a fundamental patient safety and quality assurance step in the dispensing process to adequately check the medication being dispensed against the prescription for accuracy. This involves checking that the correct medicine, dose, form, strength, and quantity is being dispensed, and checking for any interactions. Ms B's final check was clearly inadequate, given her failure to identify that the incorrect medication was being dispensed.

43. In not checking the dispensed prescription adequately, and thus allowing an incorrect medicine to be dispensed, Ms B failed to adhere to the professional standards set by the Pharmacy Council of New Zealand. Accordingly, I find that Ms B breached Right 4(2)[8] of the Code of Health and Disability Services Consumers' Rights (the Code).

Actions following the incorrect prescription — other comment

44. After it was discovered that an incorrect medication had been dispensed, Ms B asked the school nurse to ask Mrs A to return to the pharmacy with the medication. Ms B provided a verbal apology promptly after being informed of the error, notified the Pharmaceutical Defence Authority (PDA), and contacted Miss A's GP. Ms B did not provide a written apology. Two days after the error was discovered, Ms B went on leave and was off work for around four months owing to a personal injury. During this period, the pharmacy did not take any further actions in relation to Mrs A's complaint. The incorrectly dispensed medication was not returned to the pharmacy.

45. Ms Fordyce advised that accepted practice (with support from the pharmacy) is an immediate apology to the patient, discovering whether any of the incorrect drug was consumed and any harm caused, a progress update, retrieval of the incorrect medication, and notifying PDA and the patient's GP and, although not a requirement, a written apology is helpful to patients.

46. Ms B made an attempt to retrieve the incorrect drug, provided a verbal apology to Mrs A, notified the PDA, and contacted Miss A's GP. Whilst I acknowledge Ms Fordyce's advice that a written apology would have been helpful for Mrs A, two days after being made aware of the error Ms B was on leave for four months as a result of an injury. I acknowledge that Ms B may not have completed all of the steps required, but I am mindful of her unfortunate injury, and I am satisfied that in the circumstances, Ms B took reasonable steps to manage the incident appropriately once she was made aware of the error.

Opinion: Pharmacy

Dispensing error — no breach

47. The pharmacy had a duty to ensure that it provided services to Miss A with reasonable care and skill. This included ensuring that its staff provided safe, accurate, and efficient dispensing services. The pharmacy also has an obligation to ensure that it has adequate policies in place to facilitate safe and disciplined dispensing.

48. As noted above at paragraph 43, I have found Ms B in breach of Right 4(2) of the Code. Ms B accepts that she did not identify that the wrong medication was being dispensed during her final check of the medication against the prescription. As outlined at paragraph 15, the

[8] Right 4(2) states: "Every consumer has the right to have services provided that comply with legal, professional, ethical, and other relevant standards."

dispensing error occurred on Ms B's first day on the job, and she was in a new environment. I also note that subsequently Ms B determined that it was unwise to have two medications with similar names stored next to each other, and that this has been rectified.

49. Ms Fordyce advised that there was no departure from accepted practice by the pharmacy in relation to the support it provided to Ms B on her first day and in relation to its policies. I agree. Given Ms B's level of experience and her senior position, I consider that the dispensing error that occurred was attributable to Ms B as an individual failing, and did not indicate any organisational issues at the pharmacy.

Management of the dispensing error — breach

50. As noted above, once the dispensing error was discovered, Ms B informed Miss A's GP, provided a verbal apology, and notified the PDA. Three days later, Ms B went on leave for four months owing to an injury. After Ms B's initial actions, the pharmacy took no further actions, including attempting to retrieve the incorrectly dispensed medication (sertraline), contacting Mrs A, or undertaking an investigation. The pharmacy stated to HDC that the lack of investigation was caused by Ms B's accident, and the time it took to respond was affected by increased workload over the COVID-19 period.

51. The pharmacy's Dispensing Error SOP states that following a dispensing error, a full investigation must be completed and documented, including possible reasons why the event happened, how it was recognised as an error, the consequences or possible consequences, actions taken, and the outcome. The SOP also requires the pharmacy to contact and interview the patient regarding the error, and inform them of actions taken, and review its system to avoid similar incidents in the future.

52. Section O1.4 of the pharmacy's Competency Standards states that pharmacies should act to optimise health outcomes by identifying and mitigating potential sources of error in service delivery, and participate in ongoing incident analysis and adopt recommendations for resolution.

53. Ms Fordyce advised that the pharmacy should support the pharmacist in completing the necessary actions after an error is identified, and also provide an apology. Ms Fordyce also opined:

> "There would appear to have been no contact between [the pharmacy] and [Miss A] after [the pharmacy] had been informed of the dispensing error. Given that [Ms B] was off work [3] days after the error had been reported, for a period of four months, with no further contact with [Mrs A], [the pharmacy's] lack of action would constitute a moderate departure from accepted practice. [The pharmacy] did not inform [Mrs A] of any offer of financial recompense, or offer any apology — written or oral."

54. The pharmacy's failure to investigate the error meant that when a complaint was made to HDC, the pharmacy initially told HDC that Ms B had incorrectly selected, dispensed, and checked the medication. However, subsequently it was discovered that it was likely that Ms B completed only the final check.

55. I accept Ms Fordyce's advice. I am critical that at the time of the events, the pharmacy did not make more enquiries about Miss A's health, did not investigate the dispensing error, and did not offer any written or verbal apology (in addition to Ms B's verbal apology provided). I am also critical that the pharmacy did not follow its own Dispensing Error SOPs, and did not take any further actions until Mrs A brought her complaint to HDC.

56. I acknowledge that it was a busy period for the pharmacy given Ms B's unexpected leave and, a month later, COVID-19. However, the failure to undertake an adequate review, in accordance with its SOPs, represented a missed opportunity to identify how the error occurred, and to identify actions to minimise such errors in the future. Accordingly, I find that the pharmacy breached Right 4(1)[9] of the Code.

Changes and actions since incident

57. The pharmacy said that it will consider employing an extra pharmacist when a new pharmacy manager is starting, to improve the support and coverage, if the pharmacy manager has not been able to become familiar with the team and layout prior to commencing employment.

58. The pharmacy stated that following this incident, the medicines concerned, sertraline and sumatriptan, were physically separated on the shelf, and it is adapting all the relevant standardised primary healthcare group SOPs for the pharmacy.

59. Ms B told HDC that she is making the following changes to her practice:

a) Reviewing her checking procedure and analysing near miss logs.

b) Completing the Improving Accuracy and Self-Checking Workbook from the Pharmaceutical Society.

60. Ms B has provided HDC with a written apology to Mrs A.

Recommendations

61. In response to the provisional decision, Ms B advised that she has made the changes to her practice outlined in paragraph 59 and has also incorporated expert advisor Ms Fordyce's recommendations into her practice. I recommend that Ms B provide evidence of her completion of the Improving Accuracy and Self-Checking Workbook to HDC within three weeks of the date of this report.

[9] Right 4(1) states: "Every consumer has the right to have services provided with reasonable care and skill."

62. I recommend that the pharmacy:

a) Provide a written formal apology to Mrs A for the breach of the Code identified in this report, and outline the actions taken by the pharmacy to prevent such an error happening again. The apology is to be sent to HDC, for forwarding to Mrs A, within three weeks of the date of this report.

b) Arrange refresher training for its staff in relation to dispensing and checking medications and dispensing error, and provide HDC with evidence of the training and any learning, within three months of the date of this report.

c) Consider the recommendations made by the expert advisor, Ms Fordyce, in her report (at pages 11–14), and outline any further actions the pharmacy plans to take, and report back to HDC within three months of the date of this report.

d) Report back to HDC regarding its consideration to employ an extra pharmacist when a new pharmacist manager is starting, to improve the support and coverage (as stated above at paragraph 57), within three months of the date of this report.

e) Undertake a random audit of the dispensing and checking of medication of 20 prescriptions over a one-month period to assess the compliance with dispensing and checking SOPs. The pharmacy should report back to HDC regarding the result of the audit and any action plan to address the findings, within three months of the date of this report.

f) Undertake a review of any dispensing error in the last six months and whether the management of the dispensing error complied with the pharmacy's Dispensing Error SOP. The pharmacy is to report back to HDC regarding the result of the audit and any action plan to address the findings, within three months of the date of this report.

Follow-up actions

63. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Pharmacy Council of New Zealand, and it will be advised of Ms B's name.

64. A copy of this report with details identifying the parties removed, except the expert who advised on this case, will be sent to the Pharmaceutical Society of New Zealand (College Education and Training Branch), the Health Quality & Safety Commission, and the New Zealand Pharmacovigilance Centre, and placed on the Health and Disability Commissioner website, www.hdc.org.nz, for educational purposes.

Appendix A: Independent clinical advice to the Commissioner

The following expert advice was obtained from pharmacist Ms Sharynne Fordyce:

"**Amended Advice for 20HDC00383**

I, Sharynne Fordyce, have been asked to provide an opinion to the Commissioner on Case number 20HDC00383 and have read and agreed to follow the Commissioner's Guidelines for Independent Advisers.

My qualifications include a Diploma of Pharmacy, and a Masters of Clinical Pharmacy. I have worked in Retail Pharmacy for over 30 years, both in New Zealand and in England, and also work for the Wairarapa DHB.

Original Background

On 8 August 2019 at 2.42pm, [Mrs A] and her daughter ([Miss A]) presented to [the pharmacy] to fulfil a script for sumatriptan 50mg tablets for migraines. The 8 August 2019 was [Ms B], Pharmacist Manager/Sole-Charge Pharmacist, first day of employment at [the pharmacy]. At the time that [Mrs A] presented with the script (2.42pm) this was the busiest time of the day at [the pharmacy] (20 scripts were dispensed between 2.00 and 3.00pm) and the dispensing technician was on a break. [Ms B] entered, dispensed, and performed the check for [Miss A's] medication.

On 24 February 2020, a nurse at [Miss A's] school noticed that the medication inside the pack did not match the label, and rang [the pharmacy] to let them know. It was then discovered that a dispensing error had been made on 8 August 2019, and that [Miss A] was dispensed sertraline 50mg, an antidepressant, instead of sumatriptan.

Amended Background

Statements provided after my initial advice, from [Ms B], [the pharmacy], and [Ms C] indicate an altered scenario from that originally stated. [Ms C], dispensary technician, has indicated that she was 'present in [the pharmacy] and dispensing the regular prescriptions of the day so it is likely that I did so for this prescription' referring to [Miss A's] prescription. Therefore [Ms B] was responsible for performing the final check on [Miss A's] prescription only, not the processing and dispensing.

Expert advice requested

Please review the enclosed documentation and advise whether you consider the care provided to [Miss A] by [the pharmacy] was reasonable in the circumstances, and why.

In particular, please comment on:

1. The appropriateness of the training and induction provided by [the pharmacy] to [Ms B].

2. The appropriateness of the care and dispensing process by [Ms B] and whether [the pharmacy's] policies were adhered to by [Ms B].

3. The appropriateness of the subsequent actions by [the pharmacy] and [Ms B] once they were informed of the dispensing error.

4. The adequacy of the relevant standard operating procedures and policies in place at [the pharmacy] at the time of the event.

5. Any comment about any systematic issues at [the pharmacy]. If there are systemic issues, please elaborate on these with reference to how other pharmacies operate in those respects.

6. If you identify any departures from the accepted standard of care, please specify if those departures are attributable to systemic issues or to a particular individual.

7. Any other matters in this case that you consider warrant comment.

For each question, please advise:

a. What is the standard of care/accepted practice?

b. If there has been a departure from the standard of care or accepted practice, how significant a departure do you consider this to be?

c. How would it be viewed by your peers?

d. Recommendations for improvement that may help to prevent a similar occurrence in future.

1. The appropriateness of the training and induction provided by [the pharmacy] to [Ms B].

a) Given that [Ms B] was not being employed as a locum, but as a Pharmacy Business Manager a little more support (not supervision) than what was given, would have been more appropriate on her first few days. Although [Ms B] was experienced, all pharmacies differ, and there would have been new staff to meet as well as new surroundings and procedures to become acquainted with. It would be accepted practice for the previous manager to have been rostered on for the whole day, thereby enabling [Ms B] to have a rostered break, and to allow her to ask the questions that inevitably come up on the first day.

b) However, as [Ms B] had visited [the pharmacy] prior to her beginning her employment, and did have telephone access to advice from the company's other pharmacy in [the area] this would not be considered [a departure] from accepted practice.

c) This would not be viewed by my peers as a departure from accepted practice.

d) Recommendations for improvement would include providing pharmacist support and cover on a manager's (or permanent pharmacist's) first day to allow for a rostered

break. This would also allow for familiarisation with dispensary and shop layout, and staff.

2. The appropriateness of the care and dispensing process by [Ms B] and whether [the pharmacy's] policies were adhered to by [Ms B].

a) The accepted practice would involve correct processing of the prescription through the computer, the production of a clear, accurate label, the selection of the correct stock — amount, dosage form and drug — and a final check, preferably by a staff member not involved in any of the former processes, to ensure the final product is accurate, appropriate and safe for the correct patient. This process is detailed, briefly, in [the pharmacy's] policies for checking and dispensing prescriptions.

b) With failing to notice the selection and dispensing of the incorrect stock in her final check I would consider [Ms B's] actions to constitute a severe departure from accepted practice, and a moderate departure for not adhering to [the pharmacy's] policies for this procedure.

c) My peers would also consider the dispensing error a severe departure from accepted practice.

d) Recommendations for improvement would include a three-part stamp to allow for the initials of all staff involved in dispensing processes, and serve as another check. Separation on the shelves of similarly named or packaged products would help reduce picking errors. Ensuring the dispensing bench is clear and uncluttered helps reduce physical distractions.

3. The appropriateness of the subsequent actions by [the pharmacy] and [Ms B] once they were informed of the dispensing error.

a) Accepted practice for the pharmacist concerned would be an immediate apology to the patient, ascertaining whether any of the incorrect drug had been consumed, if any harm had been done to the patient, how they were now, retrieving the incorrect medication and notifying PDA and the patient's GP. The pharmacy would support the pharmacist in these actions and also provide an apology, along with a written one from the pharmacist. An offer is frequently made to the patient and/or guardian of financial recompense to cover any doctor's visits or transport costs incurred by the error.

b) There was a moderate departure from accepted practice by [Ms B] as she was not able to retrieve the incorrect medication and verify the mistake. Although, as noted by [Ms B], a written apology is not a requirement, the comprehensive and eloquent letter since furbished would have been very helpful for [Mrs A] at the time of the complaint.

There would appear to have been no contact between [the pharmacy] and [Mrs A] after [the pharmacy] had been informed of the dispensing error. Given that [Ms B] was off work [3] days after the error had been reported, for a period of four months, with no further contact with [Mrs A], [the pharmacy's] lack of action would constitute a

moderate departure from accepted practice. The pharmacy did not inform [Mrs A] of any offer of financial recompense, or offer any apology — written or oral.

c) My peers would agree with the statements above in 3(b).

d) Recommendations for improvement would include retrieval of the incorrect medication, if at all possible, and a written apology, from both [the pharmacy] and [Ms B]. This would include details of actions taken by both parties to prevent such an error happening again.

4. The adequacy of the relevant standard operating procedures and policies in place at [the pharmacy] at the time of the event.

a) The error occurred at [the pharmacy], a member of [a primary healthcare group]. Accepted practice within this group would suggest the majority of pharmacies possess [generic SOPs], adapted for individual pharmacies and areas. This practice works to ensure that all [primary healthcare group] pharmacies operate using very similar procedures. In the [primary healthcare group's] Health Job Description for Pharmacy Business Manager (the role in which [Ms B] was employed), under result area … — Operational Excellence, one of the Key Task Expectations is to 'Maintain an up to date version of [the] SOP manual'. Pharmacy Council of New Zealand (Dec 2017) recommends that for SOPs 'In the absence of any obvious changes, reviews should be undertaken at least once every two years'.

b) However, as stated in [the pharmacy's] reply to this case, the policies in place at the time of the incident had passed a recent MOH audit. This would imply that there was no departure from accepted practice.

c) My peers would also regard this as a not being a departure from accepted practice.

d) Recommendations for improvement would include the adoption of the [primary healthcare group's] SOP manual and policies, adapted for [the pharmacy], with regular reviews of all SOPs every two years.

Sharynne Fordyce

7 March 2021"

Appendix B: The pharmacy's relevant standard operating procedures

SOP 101: Dispensing a prescription, dated 26 June 2018, stated:

"PURPOSE:

To detail the procedures of dispensing a prescription.

PROCEDURE:

Responsibility of: pharmacist, Pharmacy technician and intern.

(11) Select product from shelves ...

(18) Pharmacist to make final check against prescription.

(19) Third part label (attached to prescription) to be signed by dispenser and checking pharmacist. Two initials to appear on third part label.

At each stage the dispenser should mentally check that … the correct medicine and strength is selected."

SOP 102: Procedures for checking prescription, dated 26 June 2018, stated:

"PURPOSE:

To detail the procedures of checking prescription.

PROCEDURE:

Responsibility of the pharmacist:

1. (a) check the dispensed medicine against the prescription for accuracy:

   Correct medicine, interactions, dose, form, strength and quantity …

2. Pharmacist to sign the prescription after checking."

SOP: Dispensing errors, dated 13 July 2018, stated:

"PURPOSE:

Procedure for dealing with dispensing errors

PROCEDURE:

Responsibility of Pharmacist Manager, Charge Pharmacist

These errors are dispensing errors which have been identified after the prescription has passed the final check and have been collected by the customer.

Examples relating to the type of errors/mistakes to be recorded: …

- Incorrect drug captured, chosen and/or dispensed

…

Dispensing errors:

- Must be handled sensitively by the Pharmacist Manager or Charge Pharmacist without delay.
- A full investigation of the event must be done and documented, including possible reasons why the event happened, how it was recognised as an error, the consequences or possible consequences, actions taken and the outcome.
- To be documented on Incident report form found in SOP file, as well as recorded in the computer … A summary of the incident and outcomes need to be noted.

For Medication Errors:

- The doctor of the patient needs to be informed of the error.
- Pharmacy Defence Association (PDA) needs to be notified of the error …
- Patient needs to be contacted and interviewed regarding error and informed of actions taken etc.
- The person responsible for the error needs to be counselled and/or procedures and systems need to be reviewed and updated to avoid similar incidences in the future.
- Follow-ups need to be done if necessary."

Appendix C: Relevant standards

The Pharmacy Council Code of Ethics (2018) states:

> "4 E Responds honestly, openly, courteously and promptly to complaints and criticisms.
>
> 5 C Fulfils all legal obligations
>
> 5 E Behaves in a manner that clearly demonstrates responsibility and accountability for all decisions made and actions taken in their professional practice."

The Pharmacy Council of New Zealand Competence Standards for [the pharmacy] Profession (2015) ([the pharmacy] Competency Standards) state:

> "Competency O3: Supply and administration of medicines
>
> … Pharmacists have an independent duty of care to use their professional judgement and apply their expertise to protect and promote the safety, health and well-being of patients and the public …
>
> Competency O3.2 Dispense Medicines
>
> O3.2.1 Maintains a logical, safe and disciplined dispensing procedure.
>
> O3.2.2 Monitors the dispensing process for potential errors and acts promptly to mitigate them …
>
> COMPETENCY O1.4 DELIVER QUALITY AND SAFE SERVICES Behaviours
>
> O1.4.1 Advocates for, and ensures patients access and receive quality services and care commensurate with their health needs.
>
> O1.4.2 Actively seeks to involve others (patients, carers, colleagues, other healthcare professionals) in planning for service delivery and learns from their experiences.
>
> O1.4.3 Acts to optimise health outcomes by identifying and mitigating potential sources of error in service delivery.
>
> O1.4.4 Collects and analyses safety and quality data and information that contributes to a risk management system reflecting continuous quality improvement principles.
>
> O1.4.5 Participates in ongoing incident analysis (including 'near misses') and adopts recommendations for resolution or change that come from that analysis."